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Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Note by the Secretary-General

The Secretary-General has the honour to transmit to the General Assembly the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras, submitted in accordance with Human Rights Council resolutions 6/29 and 33/9.

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Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Summary

In the present report, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health addresses the opportunities and challenges for the realization of the right to mental health of people on the move, in a global context where discriminatory attitudes and xenophobic political rhetoric have created environments of fear and intolerance. Those environments damage the quality of human relationships, bring mistrust, disrespect and intolerance into societal life, affect the realization of the right to mental health of people on the move and interfere with the right of all to mental health.

Rights-based responses to mental health and migration are presented as transformative opportunities to rebuild and strengthen health and social systems that support and restore dignity, inclusion and rights for everyone.

In the report, the Special Rapporteur presents a series of recommendations for States and relevant stakeholders within the humanitarian, development and human rights communities to address comprehensively the identified challenges.

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I. Introduction: the right to mental health and migration

1. In their previous reports, country missions and other activities, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and his predecessors have highlighted how discrimination, intolerance and a selective approach to human rights undermines the full and effective realization of the right to physical and mental health for everyone, regardless of nationality, migration status or citizenship. In the present report, the Special Rapporteur addresses the relationship between migration and the right to mental health. He focuses on the role that the right to mental health can play in scrutinizing the current political, humanitarian and public health responses to people on the move as well as in host communities and countries. He also considers how rights-based responses to mental health and migration present transformative opportunities to rebuild and strengthen health and social systems in order to support and restore dignity, inclusion and rights for everyone.

2. As we mark the seventieth anniversary of the adoption of the Universal Declaration of Human Rights, universal human rights principles are under attack. Globally, the discourse around migration and people on the move emphasizes negative portrayals rooted in misinformation and fear. This has worrying implications for the full and effective realisation of the right to health, particularly the right to mental health, for those on the move and the communities and countries that host them. As the Global Compact for Safe, Regular and Orderly Migration reaches finalization and as the world continues to grapple with human mobility coupled with severe violations of the rights of migrants and refugees, the right to mental health for all must be grounded in the context of a sustainable development agenda that seeks to realize that right equally for all people.

3. Recognizing that the right to mental health has received relatively little attention as a central component of the right to health, the Special Rapporteur highlights in the present report the specific barriers and opportunities pertinent to the realization of that right in the context of migration.

II. Terminology and scope of the report

4. There is no universal definition of people on the move. For the purposes of the present report, the term "person on the move" refers to an individual who is moving across or has crossed an international border, or has moved from their habitual place of residence, and regardless of legal status, whether the movement is voluntary or involuntary, the causes for the movement or the length of the stay.[1] Recognizing that the terminology relating to people on the move is contested, the report aims to emphasize inclusivity: regardless of whether the people are refugees, asylum seekers, migrant workers or irregular migrants, they are primarily rights-holders. The Special Rapporteur is principally concerned with those who have experienced some form of adversity owing to the nature of their departure, journey and/or reception in a new community.

5. Given the breadth and scale of the issue of migration and the right to mental health, a comprehensive assessment is not possible within the constraints of the present report. This is an initial contribution, focused on some practices where the right to mental health is a key element in meaningful assessment and guidance.

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[1] The Hague Process on Refugees and Migrants and United Nations Educational, Scientific and Cultural Organization (UNESCO), "People on the move: handbook of selected terms and concepts" (2008).

6. It is important to emphasize that being a person on the move should never be understood as a mental health issue in itself. Migration status lies exclusively in the political realm, but does have implications for mental health, which the report seeks to explore. People on the move are ordinary human beings who must leave for a variety of complex, often sociopolitical reasons.

7. People on the move have long been categorized and labelled as either "deserving" or "undeserving" of refuge or settlement based on their reasons for migrating.[2] However, greater emphasis needs to be placed on the factors that drive human mobility. Structural and political forms of violence that create poor social and economic conditions are key mobility drivers. Legal and other barriers hinder the participation of those deemed undeserving in host communities, exacerbating this structural violence and engaging significant human rights questions, including the right to mental health.[3]

8. Like all aspects of health, a range of biological, social and psychological factors affect mental health.[4] Placing our understanding of mental health within the broader landscape of a person's political, social, cultural and economic life will assist duty-bearers in identifying their obligations to respect, protect and fulfil the right to mental health.

9. Securing the right to mental health in the context of migration calls into question many complex issues, including humanitarian, fragile or war-torn States, occupied territories, urban and rural communities, robust, absent or failing national health systems and detention settings.

III. Global context: opportunities and obstacles

10. More than 250 million people live outside their country of birth.[5] According to the Office of the United Nations High Commissioner for Refugees (UNHCR), currently there are 65.6 million forcibly displaced people around the world.[6] They have been forced from their homes by violence and war, by religious, ethnic, cultural and other forms of persecution, and by famine, poverty, environmental disaster, discrimination and other forms of systemic and acute deprivations.[7] In many cases, they have left behind family, community and roots in search of safety and survival.

11. The migration of people and ideas is the foundation of the advancement of human civilization. In human history, no time or place has been unaffected by the phenomenon of people on the move and the exchange of the ideas they bring. They have shaped the communities, societies, borders and institutions we inhabit today. Migration "crises" have been a dark part of our history, from imperial pillages and sieges, genocidal incursions on indigenous lands and military and colonial

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[2] Seth M. Holmes and Heide Castañeda, "Representing the 'European refugee crisis' in Germany and beyond: deservingness and difference, life and death", *American Ethnologist*, vol. 43, No. 1 (February 2016).

[3] Ibid.

[4] See World Health Organization (WHO), *Mental Health Action Plan 2013–2020* (Geneva, 2013).

[5] United Nations, Department of Economic and Social Affairs, Population Division, "Trends in international migrant stock", International migrant stock: the 2017 revision. Available at http://www.un.org/en/development/desa/population/migration/data/estimates2/data/UN_MigrantStockTotal_2017.xlsx.

[6] Office of the United Nations High Commissioner for Refugees (UNHCR), "Figures at a Glance". Available at http://www.unhcr.org/en-us/figures-at-a-glance.html.

[7] UNHCR, "Figures at a Glance". These figures include refugees and internally displaced persons only. The larger number of migrants including migrants in vulnerable situations, many of whom move irregularly, are not included.

occupations of lands and continents. The modern context of forced migration is in many respects a legacy of those movements of domination and subjugation.

12. In recent decades, the world has experienced unprecedented movements of forcibly displaced people, originating and primarily remaining in low-income countries of the Global South. For example, almost 90 per cent of refugees seek haven in neighbouring countries and just 10 countries host 60 per cent of the global refugee population.[8]

13. In 2015, for the first time in history, more than one million refugees broke through the artificial Global North/South barrier and arrived in Europe, just as Europe was in the midst of a political and economic crisis that saw many countries mired in the harmful effects of austerity and growing socioeconomic inequality. The timing was unfortunate, as populist forces opportunistically created a narrative that the "refugee crisis" presented a threat — a misleading and simplified explanation for national discontent that has fuelled nationalistic fervour. The political and moral crisis in Europe, combined with anti-migrant-related developments in the United States of America, continue to capture headlines.[9] This has brought renewed global attention — for better or worse — to the situation of people on the move and how we respond to migration as a global community, including in the realization of the right to mental health.

14. In 2016, in the New York Declaration for Refugees and Migrants, States Members of the United Nations made a bold political commitment to protecting the rights of refugees and migrants regardless of status. As a result, in 2018, Member States will adopt two global compacts on refugees and migrants, setting the scene for more robust promotion and protection of their human rights, including their right to mental health.

15. At the same time, mental health has recently emerged as a global health, human development and human rights priority. The 2030 Agenda for Sustainable Development mentions mental health, and its inclusive approach explicitly considers refugees, internally displaced persons and migrants as people who are in a vulnerable situation and must be empowered. Within the international humanitarian sector, mental health also has become a priority with the adoption in 2007 of the Guidelines on Mental Health and Psychosocial Support in Emergency Settings. In the sphere of human rights, the Convention on the Rights of Persons with Disabilities has provided a bold and transformative foundation to mental health for persons with disabilities, including people on the move. Subsequent political commitments from the Human Rights Council, including its resolutions 32/18 and 36/13, have reaffirmed the richness of the political soil for change. Not to be dismissed are the courageous efforts of grass-roots actors, migrants and refugees, host communities and mental health workers, who have shown how resilience, tolerance, inclusion and harnessing social capital can support the well-being of entire communities. Far removed from the loud political rhetoric of fear and xenophobia, remarkable and often defiant community action should be acknowledged and promoted.

16. The above developments highlight the need to address obstacles to the realization of the right to mental health for people on the move and the broader communities that host them.

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[8] Alexander Betts and Peter Collier, *Refuge: Transforming a Broken Refugee System* (London, Allen Lane, 2017).

[9] See communications Nos. UA USA 2/2018, UA USA 27/2017, OL USA 23/2017 and UA USA 21/2017, available from https://spcommreports.ohchr.org.

A. Opportunities

Building back better: strengthening mental health systems for all

17. Worldwide, mental health systems face acute challenges, ranging from a lack of political prioritization, significant resource constraints and segregated and overmedicalized psychiatric care. The efforts under way in many parts of the world to strengthen mental health systems represent an opportunity to consider how those systems advance the realization of the right to mental health for all people, including people on the move, on an equal basis.

18. Humanitarian and development actors are beginning to recognize the need to ensure that emergency systems are aligned with broader efforts to foster sustainable development.[10] In host countries and communities, parallel health systems can stigmatize people on the move and create tensions with local communities and are not economically sustainable. Instead, health systems should strive to provide the highest quality of care and support to all people, including people on the move, on an equal basis.

19. Guidance from the World Health Organization (WHO) illustrates how emergencies can present opportunities to address the need to improve mental health systems for all people in post-emergency settings, including but not limited to people on the move.[11]

Potential contribution of migration to community well-being

20. When given an enabling environment to thrive, people on the move are overwhelmingly net contributors to the economies of their host countries and communities.[12] Research illustrates that the contribution they make to their host economies can sometimes be more than twice the cost of hosting a migrant or refugee.[13] In the past, immigrants have represented 47 per cent of the increase in the United States workforce and 70 per cent that of Europe.[14] A recent study in the United States showed that, within 6 months of resettling, 84 per cent of resettled refugees had become self-sufficient and many employed locals in their own businesses.[15] Human mobility has the potential to end extreme poverty and drive global economic growth in a manner that is sustainable, in keeping with the broader goals of the 2030 Agenda for Sustainable Development. In addition to the contribution that people on the move make by adding to the diversity of their host communities, they can also aid

[10] World Bank, "Leaders launch new humanitarian-development partnership to respond to forced displacement and global crises", press release, 16 March 2016. Available at http://www.worldbank.org/en/news/press-release/2016/03/16/new-humanitarian-development-partnership-forced-displacement-global-crises.

[11] WHO, Building Back Better: Sustainable Mental Health Care After Emergencies (Geneva, 2013); Ministry of Public Health, Mental health and substance abuse: prevention, promotion and treatment — situation analysis and strategy for Lebanon 2015–2020" (Beirut, 2015). Available at http://www.mhinnovation.net/resources/national-mental-health-strategy-lebanon#.VwxpS6s4n-l.

[12] Amandine Aubry, Michał Burzynski and Frédéric Docquier, "The welfare impact of global migration in OECD countries", Journal of International Economics, vol. 101 (July 2016); Graeme Hugo, "The economic contribution of humanitarian settlers in Australia", International Migration, vol. 52, No. 2 (April 2014); Grațiela Georgiana Noja and others, "Migrants' role in enhancing the economic development of host countries: empirical evidence from Europe", Sustainability, vol. 10, No. 3 (March 2018).

[13] International Rescue Committee, "Why are refugees good for the economy?". Available at https://www.rescue.org/video/why-are-refugees-good-economy.

[14] Organization for Economic Cooperation and Development (OECD), "Is migration good for the economy?", Migration Policy Debates, May 2014. Available at https://www.oecd.org/migration/OECD%20Migration%20Policy%20Debates%20Numero%202.pdf.

[15] Ibid.

in the creation of jobs, in counteracting the effects of ageing populations and in improving productivity.[16]

21. When enabled to participate in the economic well-being of host communities, people on the move can contribute to the overall well-being of the societies in which they reside. The importance of creating an enabling legal and policy environment for people on the move to thrive in their host communities cannot be overstated. Similarly, the diversity of ideas and contributions from people on the move can be important assets for host communities when such an environment is created. Research demonstrates the value of inclusion and "diversity dividends", noting that the knowledge, skills and expertise of diverse inhabitants can contribute economically and culturally in an increasingly globalized world.[17]

22. Holistic investment in the right to mental health of people on the move and their host communities can help to reconcile differences and confront the root causes of intolerance and exclusion, which in turn can provide a rich opportunity to promote healthy and cohesive societies.

B. Obstacles

23. In a previous report (A/HRC/35/21), the Special Rapporteur cautioned that elevating mental health as a global priority through the use of a "burden of disease" model was not enough to create the conditions necessary to bring about effective rights-based change regarding mental health in policy, law and practice. That caution rings even more loudly in the context of mental health and migration. It is essential to assess carefully the key obstacles that burden stakeholders in order to ensure that the right to mental health is prioritized in the context of migration.

Power asymmetries

24. A key obstacle to the promotion and protection of the right to mental health in the context of migration is the vast landscape of unequal power relations within the sociopolitical, health-care and sometimes even humanitarian settings. The trajectories of the lives of people on the move are largely shaped by global and national structures of power and governance and the political choices they make, which have significant implications for the right to mental health.

25. Conflict, violence and socioeconomic inequalities — by-products of powerful political structures — are key drivers of displacement and a significant determinant of mental health. Similarly, the discriminatory treatment of many people on the move in host countries reflects complex social hierarchies and power relations.[18] Politically opportunistic and xenophobic rhetoric, laws and policies have significant implications for the mental health of people on the move and their communities of departure, transit and destination.

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[16] World Bank Group, *Global Monitoring Report 2015/2016*: *Development Goals in an Era of Demographic Change* (Washington, D.C., 2016).

[17] Mark Kaplan and Mason Donovan, *Inclusion Dividend: Why Investing in Diversity and Inclusion Pays Off* (London, Routledge, 2013); Emery N. Castle, "Rural diversity: an American asset", *Annals of the American Academy of Political and Social Science*, vol. 529, No. 1 (September 1993).; Stephen Syrett and Leandro Sepulveda, "Realising the diversity dividend: population diversity and urban economic development", *Environment and Planning A: Economy and Space*, vol. 43, No. 2 (February 2011).

[18] Michele G. Shedlin and others, "Sending-country violence and receiving-country discrimination: effects on the health of Colombian refugees in Ecuador", *Journal of Immigrant and Minority Health*, vol. 16, No. 1 (February 2014).

26. Such violence has roots in unhealthy and unequal relationships among individuals and is reinforced by the failure to promote and protect good-quality human relations.[19] These hierarchies are reinforced by powerful political actors who incite fear and xenophobia, often using myths purported as facts. For example, the connection between rises in criminality and rises in migration — a proven falsehood — continues to be perpetuated. Once the cloak of "false news" is lifted, these political actors are exposed as peddlers of fear, incapable of offering real solutions for the social struggles of constituencies.

27. Creating an environment of fear and intolerance is detrimental not only to the mental health and well-being of people on the move but also of all people exposed to such rhetoric. In order to protect, respect and fulfil the right to mental health for all people, including people on the move, the barriers to the development of strong communities characterized by good-quality human relations must be addressed as a shared, global priority.

28. Those in positions of power have a responsibility to act in furtherance of the dignity and well-being of all people, including people on the move. However, recent developments in many States seem to reflect a deliberate attempt to violate the rights of people on the move or to hinder their mobility, including by introducing laws and policies that punish migrants and refugees and those who aid them.[20] Discriminatory laws, including those that criminalize people on the basis of their immigration status, can have severe implications on the human rights of people on the move, including their right to mental health.[21]

29. Within the development sector, and even within the humanitarian sector, there is a need to be self-critical about how diverse the stakeholders are who contribute to the global discourse around human mobility, protection and public health. People on the move, as those affected most directly, should be afforded a voice in responses to emergencies. The sustainability and efficacy of humanitarian responses should be prioritized, while charity-oriented models that fail to place individuals, communities and their collective rights at the centre of response mechanisms should be avoided.

30. Traditionally, the mental health care and support services provided in many humanitarian settings view individuals as passive recipients of aid,[22] while paternalistic and donor-driven humanitarian responses have dominated the global response to emergencies.[23] These top-down approaches highlight the power

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[19] See A/HRC/29/33, para. 107.

[20] Office of the United Nations High Commissioner for Human Rights (OHCHR), "United Nations experts to United States: 'Release migrant children from detention and stop using them to deter irregular migration'", 22 June 2018. Available at https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=23245&LangID=E; OHCHR, "Thailand: United Nations experts condemn use of defamation laws to silence human rights defender Andy Hall", 17 May 2018. Available at https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=23095&LangID=E; OHCHR, "Confronting the two faces of racism: resurgent hate and structural discrimination", 21 March 2018. Available at https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=22856&LangID=E.

[21] Asian Pacific American Institute for Congressional Studies, "APAICS and AAPI coalition express concerns about the xenophobic rhetoric in 2010 campaigns", 1 November 2010. Available at http://apaics.org/2010/11/01/apaics-and-aapi-coalition-express-concerns-about-the-xenophobic-rhetoric-in-2010-campaigns/.

[22] Lisa Schwartz and others, "Ethics in humanitarian aid work: learning from the narratives of humanitarian health workers", *AJOB Primary Research*, vol. 1, No. 3 (2010).

[23] Michael Barnett, "Humanitarianism, paternalism and the UNHCR", in *Refugees in International Relations*, Alexander Betts and Gil Loescher, eds. (Oxford, Oxford University Press, 2011); Vanessa Pupavac, "Global disaster management and therapeutic governance of communities", *Development Dialogue*, No. 58 (April 2012).

imbalances of humanitarian settings and should be revise for two important reasons: (a) they devalue the participation of people on the move in their own well-being; and (b) they trap individuals in a confined narrative of psychological trauma or "disorder" that fails to contextualize their complex social, economic and political lives. Top-down, vertical programmes that seek to "treat" mental health conditions as diseases should not dominate. Instead, interventions should be developed that emphasize the participation of people on the move in their own well-being and consider their circumstances as part of a broader sociopolitical ecosystem.

Dominance of the biomedical approach and the pathologization of adversity

31. The use of alarming statistics to indicate the scale and economic burden of "mental disorders" has been a strategic and politically useful device to elevate mental health as a global priority. However, the Special Rapporteur recalls that framing the issue as such firmly roots the global mental health crisis within a biomedical model, involving neurobiological factors and processes as the dominant explanation and response to poor mental health. Currently, the majority of investments relating to mental health in low-, middle- and high-income countries are disproportionately geared towards funding services based on the biomedical model of psychiatry — inpatient treatment, medications and institutional care.[24] With this, the focus is less on policy, empowerment and investing in enabling conditions, and more on treating individual conditions, leading to ineffective and potentially harmful outcomes. Importantly, this makes policymakers give less of a priority to addressing the main risk and protective factors affecting mental health for everyone, including in the context of migration.

32. Similarly, over the past two decades, the mental health needs of people on the move have gained significant visibility thanks to the strategic use of the term "trauma" to characterize the suffering and adversity that those subjected to forced displacement in the migration process face.[25] The discourse from a trauma perspective has highlighted the previously invisible factors of distress, including the structural violence of conflict, loss of home and the stultifying nature of forcible displacement. However, the discourse has also translated into a trauma-related clinical practice in the form of individualized psychosocial counselling and medication. This in turn has obscured the main protection risks and the factors essential for positive well-being, and ignored the social and political meaning that the collective experience of displacement represents for many.[26] The vast majority of people on the move experience normal emotional reactions to often extraordinary external stressors and suffering. To view those responses within the medical framework of "trauma", "disorder" or "illness" traps individuals in a narrative that limits the richness and possibility of their human story. It is concerning how that framework can lead to paternalism, thereby undervaluing and undermining the inherent power and agency of individuals as active participants in their mental health and empowered rights holders, as opposed to passive recipients of care. While a small number of people on the move do experience significant mental health challenges and require individualized care and support, the excessive pathologization of the effects of human mobility should be avoided.

33. The insufficient quality of health-care professionals can be a significant obstacle owing to the reductive skills and bias many bring to mental health settings. The

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[24] See A/HRC/35/21, paras. 18–29; see also Human Rights Council resolution 36/13, para. 9.

[25] Didier Fassin and Richard Rechtman, The Empire of Trauma: An Inquiry into the Condition of Victimhood (Princeton, Princeton University Press, 2009); Miranda Alcock, "Refugee trauma: the assault on meaning", Psychodynamic Practice, vol. 9, No. 3 (2003).

[26] Rita Giacaman and others, "Mental health, social distress and political oppression: the case of the occupied Palestinian territory", *Global Public Health*, vol. 6, No. 5 (July 2011).

paternalism inherent within the biomedical model and trauma frameworks remains a legacy of mental health training and influences how care is developed and delivered. Key stakeholders, despite their best intentions to provide care to people on the move, have a tendency to overpathologize the experience of human mobility and underemphasize the significance of the social, political, cultural, spiritual and economic determinants of mental health and well-being.[27] It is therefore necessary to consider ways to overcome those obstacles in the training and diversification of such professionals.

IV. Right to mental health framework and people on the move

A. Obligations

34. The International Covenant on Economic, Social and Cultural Rights provides a legally binding framework for the right to the enjoyment of the highest attainable standard of physical and mental health. This is complemented by a range of legal instruments, including the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Rights of Persons with Disabilities, the Convention on the Elimination of All Forms of Discrimination against Women, the International Convention on the Protection of the Rights of all Migrant Workers and Members of Their Families, the Convention Relating to the Status of Refugees and the Convention on the Rights of the Child. States parties have an obligation to respect, protect and fulfil the right to physical and mental health in national laws, policies, budgetary measures, programmes and other initiatives.

35. The right to physical and mental health includes the immediate obligations and requirements of States to take deliberate, concrete and targeted actions in order to realize that right progressively.[28] However, certain core obligations are not subject to progressive realization and must be implemented immediately. They include the elaboration of a national public health strategy and non-discriminatory access to services. Regarding the right to mental health, this means: (a) the development of a national mental health strategy that includes people on the move; (b) a concrete plan to develop a coordination mechanism to address the health and well-being of people on the move, including the people themselves as well as humanitarian actors and communities; and (c) a road map leading away from coercive treatment and towards equal access to rights-based mental health services, including the equitable distribution of services in the community.

36. The prohibition of discrimination, including on the grounds of national origin, birth or legal status, is also a core obligation that is not subject to progressive realization.[29] States are obliged to respect, protect and fulfil the right to mental health of all people on their territory or under their effective control, regardless of their

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[27] Vanessa Pupavac, "Therapeutising refugees, pathologising populations: international psycho-social programmes in Kosovo", New Issues In Refugee Research, Working Paper No. 59. Available at https://reliefweb.int/sites/reliefweb.int/files/resources/77E8853E90165CCDC1256C610035083E-hcr-therapeurising-aug02.pdf; D. Bhugra and others, "EPA guidance mental health care and migrants", *European Psychiatry*, vol. 29, No. 2 (February 2014); Milica Pejovic-Milovancevic, Henrikje Klasen and Dimitris Anagnostopoulos, "ESCAP for mental health of child and adolescent refugees: facing the challenge together, reducing risk, and promoting healthy development", *European Child and Adolescent Psychiatry*, vol. 27, No. 2 (February 2018).

[28] International Covenant on Economic, Social and Cultural Rights, art. 2 (1).

[29] Ibid., art. 2 (2), and Committee on Economic, Social and Cultural Rights general comments No. 14 (2000) on the right to the highest attainable standard of health, para. 43 (a), and No. 20 (2009) on non-discrimination in economic, social and cultural rights, para. 30.

migrant, refugee or other legal status. The very presence of people on the move within a State's jurisdiction — whether in a regular or irregular status — imposes obligations on that State regarding the right to health.

37. People on the move should not be denied the right to migrate by countries of origin, transit or destination on the basis of either their health — including mental health—or disability status. Refusing a person on the move a residence permit, family reunification or naturalization solely on the basis of his or her health — including mental health and disability status — amounts to unlawful discrimination.[30]

B. International cooperation and assistance

38. International human rights treaties recognize the obligation of States to cooperate to ensure the right to physical and mental health, a responsibility reiterated in the 2030 Agenda for Sustainable Development and echoed in discussions for the global compacts on refugees and migrants. Higher-income States have a particular duty to provide assistance to ensure the right to physical and mental health in lower-income countries. There is an immediate obligation to refrain from providing development cooperation that supports mental health-care systems that are discriminatory or where violence, torture and other human rights violations occur, including within humanitarian or emergency settings. Rights-based development cooperation should support balanced mental health promotion alongside psychosocial interventions and other treatment alternatives, delivered in the community. Far too often, international humanitarian assistance — particularly for mental health — is delivered as short-term, "emergency" support. This forces care to be delivered as reactive and individualistic programme models, often measured by biomedical indicators such as numbers of people treated. In fact, long-term investment is required in order to strengthen mental health systems and ensure they respond to and address the full range of social, economic, psychological and biological factors that produce poor mental health for people on the move and the broader communities in which they live. Many States have recognized the need to introduce a shift in governance mechanisms to support that long-term vision for sustainable and rights-based development, and to merge their international humanitarian and development mechanisms. More States should consider the barriers their governance mechanisms pose to sustainable, rights-based international cooperation.

39. Exclusion and toxic community relations are a central barrier to the realization of the right to mental health in the context of migration. Likewise, exclusion leads to significant economic costs to communities. International assistance must continue to move beyond individualistic treatment paradigms towards more holistic models of collective healing for communities, with a focus on the key determinants of mental health, including healthy community relationships and inclusion. Participatory frameworks should be explored to identify and implement appropriate local models.

40. Despite rhetorical shifts in recent years, mental health globally remains severely underfunded. Between 2007 and 2013, only 1 per cent of international health aid went to mental health.[31] This illustrates the broad lack of prioritization for mental health as a global issue. This is mirrored in humanitarian settings, where similar constraints have been noted and the unmet need for rights-based mental health care and support interventions have been documented.[32] Resource constraints represent a considerable

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[30] Article 5 of the Convention on the Rights of Persons with Disabilities recognizes that all persons are entitled without discrimination to the equal protection and equal benefit of the law.

[31] See A/HRC/35/21, para. 39.

[32] Wietse Tol, "Mental health and psychosocial support in humanitarian settings: linking practice and research", *Lancet*, vol. 378, No. 9802 (October 2011).

barrier to the realization of the right to mental health in humanitarian settings. Funding for mental health should always support interventions that are rights-affirming and should never support interventions that lead to human rights violations. The Special Rapporteur highlights the fact that the right to mental health for people on the move cannot be realized without adequate funding, and urges a new generation of international donor champions to take on that challenge.

41. International assistance and cooperation also includes technical support for rights-based mental health policies and practices in the context of migration. The WHO QualityRights initiative is a commendable example of such technical assistance and has been implemented successfully to address mental health and migration in several countries, including Lebanon, which is host to a very high number of people on the move and where the integration of mental health and migration policies and services is exemplary.

42. Likewise, the Inter-Agency Standing Committee task force on mental health has developed a set of guidelines for the coordination of mental health care and support services in emergency settings. Key features of the guidelines include an emphasis on human rights, equality and the participation of individuals and communities in all decisions regarding their own mental health and well-being.[33] However, awareness of the guidelines remains suboptimal, and the quality of psychosocial supports has been questioned.[34] The expertise and experience of the task force should be used to develop best practices, strengthen more inclusive collaboration and support knowledge-sharing, while ensuring the participation of affected communities and a rights-based approach to mental health.

C. Participation and access to information

43. Participation is not only a human right but has also been shown to be a determinant for psychological well-being.[35] WHO considers the ability of an individual to make a contribution to his or her community as a component of mental health.[36] The effective realization of the right to mental health requires that everyone be involved in decisions relating to their own well-being. It is therefore incumbent upon host environments to facilitate the participation of people on the move through legal and policy means as well as efforts aimed at social integration.

44. People on the move have the right to participate in their own care and support as decision-makers and as co-creators of support regimes. Restrictions on their ability to work, obtain an education or otherwise participate meaningfully and equally in their host communities are incompatible with the right to health and should be eliminated.

45. There are numerous ways in which participation can and should be facilitated in the context of human mobility. Participation in policy development could include the use of participatory methods to develop an understanding of the local context in which mental health care and support services are to be delivered, as well as the needs

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[33] Inter-Agency Standing Committee, *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (Geneva, 2007).

[34] Inter-Agency Standing Committee, *Review of the Implementation of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (2014).

[35] I. Kawachi and L. Berkman, “Social ties and mental health”, *Journal of Urban Health*, vol. 78, No. 3 (September 2001).

[36] WHO and Calouste Gulbenkian Foundation, *Social Determinants of Mental Health* (Geneva, WHO, 2014).

of affected individuals and communities. This model has proved useful in the past.[37] People on the move have participated in initiatives to improve mental health and well-being as cultural mediators, peer supporters, community interpreters and health-care workers. These approaches have been shown to enhance the efficacy of interventions and to promote rights as well as the improved quality of care and support.[38]

46. Timely and accurate information on the right to mental health and mental health care and support services should be made available to people on the move at all stages of their journey, along migratory routes, at reception points and in communities where they live and work. It should be provided in a language and format that they can understand and should state clearly that they are entitled to care and support services on an equal basis with others.

D. Accountability

47. Monitoring the right to mental health of people on the move means monitoring not only the efficacy of mental health care and support services, but also the human rights impact of policies, including immigration policies, on mental health and well-being. States are therefore urged to engage in regular and impartial monitoring of all policies and services that may play a role in the mental health and well-being of people on the move.

48. The role of national human rights institutions, United Nations human rights mechanisms and civil society in the accountability process is especially important. Similarly, human rights monitoring of responses to emergencies should be a key feature of all humanitarian responses. Humanitarian organizations and international donors have a responsibility to uphold the highest standards of transparency to support the accountability process.

E. Social determinants of mental health in the context of migration

49. A rights-based approach to mental health recognizes that the broader social environment in which a person — including a person on the move — finds himself or herself is a determinant of mental health. Consequently, the increasing levels of marginalization and prevailing negative attitudes towards people on the move in many contexts are a cause of concern. Societal-level concerns that have shown to have a relationship with mental health include the need for safety, including safety in the context of intimate relationships;[39] the need for meaningful human relationships;[40] and the need for education and work opportunities and for an adequate standard of living.[41]

50. Addressing societal and community-level concerns can improve the mental health and well-being of all people, including people on the move, and can contribute

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[37] Susan McKay and others, "Building meaningful participation in (re)integration among war-affected young mothers in Liberia, Sierra Leone and northern Uganda", *Intervention*, vol. 9, No. 2 (July 2011).

[38] Barbara Kieft and others, "Paraprofessional counselling within asylum seekers' groups in the Netherlands: transferring an approach for a non-western context to a European setting", *Transcultural Psychiatry*, vol. 45, No. 1 (2008); Constanze Quosh, "Takamol: multi-professional capacity building in order to strengthen the psychosocial and mental health sector in response to refugee crises in Syria", Intervention, vol. 9, No. 3 (2011).

[39] Ann Coker and others, "Social support protects against the negative effects of partner violence on mental health", *Journal of Women's Health and Gender-Based Medicine*, vol. 11, No. 5

[40] Kawachi and Berkman, "Social ties and mental health".

[41] WHO and Calouste Gulbenkian Foundation, "Social determinants of mental health".

significantly to the realization of the right to mental health for all. The Special Rapporteur reiterates that the mental health of all people in any society can benefit significantly from laws, policies and social interventions that foster enabling environments for everybody to develop fulfilling relationships and to contribute meaningfully to the community.[42]

F. Care and support

51. While it is necessary to ensure that those who do experience mental health challenges are provided with adequate care and support, it is vital to recognize that most people on the move experience normal responses to adversity that should not be pathologized as individual conditions. Hence, the mental health implications of the experiences of people on the move are part of a spectrum, and the relevant interventions and policies should therefore include approaches that are equally diverse. The availability, acceptability, accessibility and quality framework[43] should be applied to mental health care and support interventions that cater to all segments of that spectrum.

Availability

52. Availability requires States to put in place individual screening and assessment procedures to assess an individual's mental health and well-being as well as the human rights situation of people on the move.[44] Through those mechanisms, it should be possible to identify survivors of sexual and gender-based violence and torture as well as other people on the move with mental health and well-being needs, and to ensure they are referred to the appropriate health and protection services.

53. Mental health care and support services should not only be available for people on the move but should also be appropriate and not infringe on the rights of those affected. Overuse of biomedical interventions or overemphasis on psychological trauma should be eschewed for interventions that emphasize the right of people on the move to live freely in their communities and to be given opportunities to thrive. Efforts should be made to ensure that mental health care and support services are rights-based and available to people on the move on an equal basis with nationals, rather than in parallel systems. Globally, harm reduction services remain critically underfunded, and this is compounded for people on the move.[45]

54. Throughout the world, mental health care and support workforce shortages have been a significant impediment to access to services.[46] Humanitarian settings also face such shortages,[47] which is a major challenge for the implementation of the Inter-

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[42] See A/HRC/35/21 paras. 67–68.
[43] See Committee on Economic, Social and Cultural Rights general comments No. 14, para. 12.
[44] See, for example WHO and UNHCR, *Assessing mental health and psychosocial needs and resources: toolkit for humanitarian settings* (Geneva, WHO, 2012).
[45] European Monitoring Centre for Drugs and Drug Addiction, "Migrants, asylum seekers and refugees: an overview of the literature relating to drug use and access to services — background paper: a European guide" (2017). Available at http://www.emcdda.europa.eu/system/files/attachments/6341/EuropeanResponsesGuide2017_BackgroundPaper-Migrants-Asylum-seekers-Refugees-Drug-use.pdf.
[46] WHO, *Mental Health Atlas* (Geneva, 2018).
[47] International Medical Corps, "Mental health and psychosocial support considerations for Syrian refugees in Turkey: sources of distress, coping mechanisms, and access to support" (Los Angeles, CA and Washington, D.C., 2017).

Agency Standing Committee guidelines.[48] Community-based care and peer support models are a means to overcome workforce scarcity.[49]

Accessibility

55. In recent years, States have increased the use of restrictive and punitive immigration policies as a means to deter migration.[50] Such policies have contributed to a risk environment where human rights violations are more likely to and do occur, including at the hands of State officials.[51] The development of immigration policies that focus on inclusion and that cater to life in a community of peers has been shown to be supportive of well-being.[52] States should work actively towards the development of such laws and policies.

56. The Special Rapporteur on the human rights of migrants and the previous Special Rapporteur on the right to health have noted that the health needs of irregular or undocumented migrants are often systematically and irreversibly left unmet.[53] In some countries, people on the move in irregular situations are excluded by law or policies and/or in practice and only permitted to obtain emergency medical care, often at a cost, thus denying them the primary or secondary care they need, including mental health care and support services. Similarly, where social services and health-care workers are obliged — by law, policy or practice — to report irregular migrants to the immigration or other public authorities, people on the move are unable to gain access to services out of fear of being arrested, detained and deported. This constitutes a violation of the right to privacy, as well as an impediment to the realization of the right to health. The use of "firewall" measures that allow people on the move to interact freely with public officials to report violations has been identified as a policy solution to separate immigration enforcement and facilitate access to service provision.[54]

57. Mental health care and support services should be accessible to people on the move with disabilities on an equal basis with others. The physical accessibility of service settings for people on the move with disabilities has been highlighted as a challenge that requires urgent rectification if the right to physical and mental health is to be realized in a manner that does not discriminate.[55] Similarly, accommodations in mental health care and support services for persons with intellectual, cognitive or psychosocial disabilities should be made available and should recognize that the spectrum of functions and abilities prevalent in all populations also applies to people on the move.

58. To ensure the accessibility of mental health care and support services, geographical, cultural and linguistic barriers should be addressed through capacity-

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[48] Inter-Agency Standing Committee, *Review of the Implementation of the IASC Guidelines*.

[49] T. Hoeft and others, "Task-sharing approaches to improve mental health care in rural and other low-resource settings: a systematic review", *The Journal of Rural Health*, vol. 34, No. 1 (December 2018); Carolyn Williams, "The Southeast Asian refugees and community mental health", *Journal of Community Psychology*, vol. 13 (July 1985).

[50] International Federation of Red Cross and Red Crescent Societies, "New walled order: how barriers to basic services turn migration into a humanitarian crisis" (2018). Available at http://media.ifrc.org/ifrc/wp-content/uploads/sites/5/2018/07/180628-Migration-policy-report-A4-EN.pdf.

[51] Ibid. See also A/72/335.

[52] Ibid.

[53] A/HRC/17/33 and A/HRC/23/41.

[54] François Crépeau and Bethany Hastie, "The case for 'firewall' protections for irregular migrants: safeguarding fundamental rights", *European Journal of Migration and Law*, vol. 17 (June 2015).

[55] Human Rights Watch, "Greece: refugees with disabilities overlooked, underserved", 18 January 2017. Available at https://www.hrw.org/news/2017/01/18/greece-refugees-disabilities-overlooked-underserved.

building, the provision of remote and mobile services, interpreters, outreach activities and language and culturally appropriate care and support that recognizes the specific needs and sensitivities of the people who use them.

Acceptability

59. An acceptable approach to mental health and well-being for people on the move must consider the diversity of backgrounds, which can inform experiences of migration and the post-migration integration process. To be acceptable, mental health care and support services should be sensitive to issues of culture, religion, language and context. Research has demonstrated that people on the move of differing backgrounds experience the mental health effects of migration and displacement in different ways,[56] and this should be considered through the inclusive participation of communities when interventions are designed and implemented. Biomedical models of care and support that tend to be "exported" to other regions of the world[57] may not always be suitable to other contexts. The development of local solutions, based on evidence and human rights, is necessary in order to ensure that the services provided are acceptable.

60. In some settings, the phenomenon of "medical xenophobia" has been documented, whereby health-care workers are involved in denying access to services for people on the move.[58] Discrimination can also have the effect of discouraging people on the move from seeking mental health care and support services when they need them, resulting in further adverse outcomes.[59] This is indicative of the need for engagement with all workers about the right of all people, including people on the move, to mental health. States should be active in taking steps to ensure that discrimination in mental health care and support settings is eliminated, including through policy measures and training. Human rights education should be incorporated into the training of all workers interacting with people on the move. Important work is being done by medical professional organizations, including the World Medical Association[60] and the World Psychiatric Association,[61] to confront structural violence and discrimination.[62] These initiatives are welcomed and encouraged. One also

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[56] M. Terheggen, M. Stroebe and R. Kleber, "Western conceptualizations and eastern experience: a cross-cultural study of traumatic stress reactions among Tibetan refugees in India", *Journal of Traumatic Stress*, vol. 14, No. 2 (April 2001); Laurence Kirmayer, "Common mental health problems in immigrants and refugees: general approach in primary care", *Canadian Medical Association Journal*, vol. 183, No. 12 (September 2011).

[57] Richard Bentall, "Western models for mental health: a cautionary note", Commonwealth Health Partnerships (2014). Available at http://www.commonwealthhealth.org/wp-content/uploads/2014/05/5-Western-models-for-mental-health-bentall.pdf.

[58] Orateng Lepodise, "Medical xenophobia: public hospitals deny migrants health care services — South African Human Rights Commission", 29 March 2018. Available at https://www.dailymaverick.co.za/article/2018-03-29-medical-xenophobia-public-hospitals-deny-migrants-health-care-services-sahrc/#.WxFXCUgvzD6.

[59] Ibid.

[60] World Medical Association, "WMA resolution on refugees and migrants". Available at www.wma.net/policies-post/wma-resolution-on-refugees-and-migrants/.

[61] World Psychiatric Association, "WPA position statement migrant crisis", 2016. Available at http://www.wpanet.org/detail.php?section_id=7&content_id=1772.

[62] See, for example, British Dental Association "X-rays for young asylum seekers: inaccurate and unethical", 23 November 2015. Available at https://www.bda.org/news-centre/latest-news-articles/Pages/Xrays-for-young-asylum-seekers-inaccurate-and-unethical.aspx; Colleen Kraft, "AAP statement opposing separation of children and parents at the border", American Academy of Pediatrics, 8 May 2018. Available at https://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/StatementOpposingSeparationofChildrenandParents.aspx; American College of Physicians, "Immigration position statement", 30 January 2017. Available at https://www.acponline.org/acp_policy/policies/immigration_position_statement_2017.pdf.

cannot ignore the broader structural forces that produce discriminatory attitudes, as all health-care workers also are people living in communities.[63]

Quality

61. The quality of mental health care and support services is a necessary condition for the right to mental health to be realized. Mental health care and support services for migrants should include prevention, promotion, treatment, recovery and growth. The excessive use of biomedical interventions, including the inappropriate use or overprescription of psychotropic medications and the use of coercion and forced admissions, compromise the right to quality care and support. The stressors faced by people on the move need not be pathologized and automatically treated as biomedical "illnesses". Instead, an approach that recognizes the value of all interventions, including non-specialized and mental health-promoting interventions geared towards well-being, is required.

62. Training and capacity-building on mental health models that do not pathologize or medicalize the experience of human mobility or overemphasize biomedical interventions but instead recognize the value of an approach that is rooted in the development of human relationships should be prioritized in the process of strengthening mental health systems. Capacity-building should also consider the need for a human rights-based approach and should be geared towards care that is culturally appropriate and that recognizes the specific social, legal, financial and political circumstances of those on the move.

63. Culturally competent care and support services are an essential fixture in the realization of the right to mental health. This entails ensuring that the specific sociocultural needs of people on the move are met on an equal basis with others making use of a particular service, recognizing specific linguistic, ethnic, religious and other cultural factors. Incorporating people on the move into the framework of support for their peers is one means by which care and support services can be made more culturally appropriate. The training and use of mental health advocates, peer supporters, community outreach volunteers and cultural mediators from refugee, internally displaced or migrant communities have proved useful and should be replicated.[64]

64. Health-care workers possess an ethical duty to care in all instances but are often asked to act as immigration enforcement officials where people on the move are concerned.[65] States should recognize that this ethical challenge can be a significant impediment to the realization of the right to physical and mental health of people on the move and should take all steps necessary to ensure that health-care workers, whose primary obligation is to provide services to those who require it, are not faced with this obstacle.

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[63] Seth M. Holmes and Philippe Bourgois, *Fresh Fruit, Broken Bodies: Migrant Farmworkers in the United States* (Berkley, University of California Press, 2013).

[64] Mind, *Improving Mental Health Support for Refugee Communities: An Advocacy Approach* (London, 2009). Available at https://www.mind.org.uk/media/192447/Refugee_Report_1.pdf; Kieft and others "Paraprofessional counselling within asylum seekers' groups in the Netherlands" (see footnote 39); Quosh, "Takamol" (see footnote 39); P. Ventevogel, "Capitalization: psychosocial services and training institute in Cairo" (unpublished).

[65] D. Biswas and others, "Access to health care for undocumented migrants from a human rights perspective: a comparative study of Denmark, Sweden, and the Netherlands", Health and Human Rights, vol. 14, No. 2 (December 2012).

V. Issues in focus

65. In keeping with the Special Rapporteur's continued wish to prioritize the healthy development of children and young people, special attention must be paid to the right to mental health of children and families on the move. Similarly, the Special Rapporteur's most recent report on deprivation of liberty highlights the broad impact this has on mental health and raises concerns around the protection of the right to mental health within punitive models of confinement. As immigration detention is a default strategy in many parts of the world for regulating human mobility, the present report examines the issue from the perspective of the right to mental health.

A. Children and families

66. The family system is a key foundation of mental health and well-being, particularly for children and adolescents, and has been a central focus of the historical development of immigration policies and legislation the world over.[66] This reflects a shared and universal value for family unity regardless of ideological, geographic and cultural differences.[67] The undermining of family unity in the context of human mobility and its detrimental impact on the mental health and well-being of children and adolescents on the move is a rights violation and presents a challenge whose effects could last for years or even generations to come.

67. As highlighted by the Special Rapporteur in his previous reports, key supportive factors that can aid in the realization of the right to mental health include a stable family environment and participation in a community that includes strong peer relationships.[68] Environments where children and adolescents are able to flourish, that cater to their needs for safety and non-violence,[69] that allow for healthy relationships to form[70] and that ensure access to quality education[71] can significantly enhance the mental health and well-being of all children and young people. States should take all steps necessary to ensure that those environments are available for all children and adolescents, including those on the move.

68. The Special Rapporteur has highlighted States' obligation to provide quality, acceptable, accessible and available mental health care and support services for all children and adolescents. He has also noted that, despite those obligations, there is a worrying lack of recognition of the nature and scale of mental health and well-being needs of young people.[72] Globally, there is an undercapacity of child and adolescent mental health care and support services,[73] and the overuse of institutional care and biomedical interventions that is evident in mental health-care systems is also evident in the realm of child and adolescent mental health care and support.[74] All children and

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[66] Stephen Legomsky, "Immigration, equality and diversity", *Columbia Journal of Transnational Law*, vol. 31, No. 2 (1993).

[67] M. Hirschfield and D. Wikler, "An Ethics Perspective on Family Caregiving Worldwide: Justice and Society's Obligations", in *Generations*, No. 4, Vol. 27.

[68] A/HRC/29/33, A/HRC/32/32 and A/HRC/35/21.

[69] Mina Fazel and others, "Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors", *The Lancet*, vol. 379, No. 9812 (January 2012).

[70] Bonnie Benard, *Fostering Resiliency in Kids: Protective Factors in the Family, School, and Community* (Washington D.C., Department of Education, 1991).

[71] M. Atkins and others, "Toward the integration of education and mental health in schools", *Administration and Policy in Mental Health and Mental Health Services Research*, vol. 37, Nos. 1–2 (March 2010).

[72] See A/HRC/32/32, para. 71.

[73] Panos Vostanis, "Global child mental health: emerging challenges and opportunities", *Child and Adolescent Mental Health*, vol. 22, No. 4 (2017).

[74] See A/HRC/32/32, para. 15.

adolescents, including children and adolescents on the move, possess an inalienable right to mental health that States must take active steps to realize, including through the expansion of care and support services that adhere to a rights-based approach and that recognize the social, cultural, economic, legal and political determinants of mental health and well-being.

69. The Convention on the Rights of the Child establishes the paramount principle of the best interests of the child for all matters concerning them. This standard applies to all children and adolescents on the move. Despite this, violations of the rights of children on the move to education,[75] social protection,[76] health,[77] safety and security,[78] access to justice,[79] freedom from torture, cruel, inhuman and degrading treatment[80] and non-discrimination[81] have been documented and all of these can have significant implications for their mental health and well-being. The Special Rapporteur calls upon States to harmonize with the Convention all official laws, policies and protocols regarding migration and displacement without delay.

70. Efforts aimed at family reunification can have significant positive implications for the mental health of children and adolescents on the move. However, the deliberate obfuscation of policies supporting family reunification has been documented. This contravenes the best interests of the child, violates the rights of the child to family unity and to physical and mental health and compromises not only the full and harmonious development of children, but also their mental well-being and potential for psychological and cognitive growth. Laws and policies that institutionalize the separation of children on the move from their families contribute significantly to adverse mental health outcomes and should be repealed without delay.

71. Children and adolescents in an irregular migration situation may also be at risk of adverse mental health outcomes. States should be mindful of the considerable psychological difficulties visited upon children and adolescents who either are themselves facing deportation or have family members who may be facing deportation.[82] The standard of the best interests of the child should be the paramount consideration when such decisions are contemplated, including in policy and legislation.

72. Early childhood interventions, including early childhood development programming, should be made available to children on the move on an equal basis with all other children. The importance of early childhood development programming

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[75] United Nations Children's Fund (UNICEF), "Refugee and migrant children stuck in Greece face double crisis", press release, 26 August 2016. Available at https://www.unicef.org/media/media_92675.html.

[76] Ibid.

[77] Human Rights Watch, "Jordan: step forward, step back for urban refugees: they get legal status, but lose health subsidies", 29 March 2018 (updated). Available at https://www.hrw.org/news/2018/03/25/jordan-step-forward-step-back-urban-refugees; Erica Moretti, "How to help Syria's refugee children", *Washington Post*, 8 March 2018. Available at https://www.washingtonpost.com/news/made-by-history/wp/2018/03/08/how-to-help-syrias-refugee-children/?utm_term=.0e0b84fedb88.

[78] Atika Shubert, Bharati Naik and Bryony Jones, "Refugee life, as seen by children fleeing war", CNN, 20 June 2016. Available at https://www.cnn.com/2016/06/20/europe/child-refugees-greece/index.html.

[79] European Council on Refugees and Exiles, "Right to justice: quality legal assistance for unaccompanied children — comparative report" (2014).

[80] Harriet Grant, "Home Office faces court action over asylum children", The Guardian, 24 April 2018.

[81] Zeynep Doğusan, "Refugee children discriminated against in Germany, UNICEF says", Daily Sabah Europe, 10 September 2014.

[82] Medical Express, "Ending DACA could have dire public health consequences", 15 September 2017. Available at https://medicalxpress.com/news/2017-09-daca-dire-health-consequences.html.

should not be underestimated, given the high potential for adaptability of infants and toddlers and the capacity for recovery from acute stressors when the necessary support is provided. Likewise, enabling a safe and supportive school environment is an utmost precondition for positive mental health. Too often, children are isolated, bullied or punished on the basis of their migration status.

B. Detention

73. In his report on deprivation of liberty and the right to health, the Special Rapporteur notes that immigration detention is becoming increasingly common and has severe implications for the mental health and well-being of people on the move.[83] In numerous cases, immigration detention occurs without due process.

74. Research has demonstrated that the detention of people on the move in inhumane conditions can have adverse mental health implications.[84] Immigration detention may also exacerbate existing mental health challenges. The mental health challenges visited upon people on the move during the process of detention also persist after detention and can have adverse effects on their quality of life.[85] Data also clearly suggests that detention as a form of deterrence is ineffective.

75. The Working Group on Arbitrary Detention has stated that immigration detention should gradually be abolished.[86] In echoing that statement, and relevant United Nations guidelines,[87] the Special Rapporteur recommends that States establish in law a presumption against immigration detention, work progressively to end all forms of immigration detention and prioritize the implementation of non-custodial, community-based alternatives to detention.

76. The arbitrary detention of persons with intellectual, cognitive and psychosocial disabilities also occurs in the context of migration and displacement. The Convention on the Rights of Persons with Disabilities places an absolute ban on deprivation of liberty based on disability. That practice violates the rights to personal liberty and to security[88] and may amount to a violation of the right to live free from torture and ill-treatment.[89] It likewise comes into conflict with the right to mental health.

VI. Conclusions and recommendations

77. **The present report provides the opportunity to address, in an integrated manner, two major issues of modern times: the unprecedented movement of people who have been forcibly displaced in the most recent decades and the recent recognition of mental health as a global priority.**

78. **The issues have various common denominators, and the first and most important lesson they present is the need to address and abandon discriminatory policies and practices that are fuelled by negative attitudes and hostile rhetoric against people on the move. The environment of fear and intolerance that results**

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[83] See A/HRC/38/36, para. 14.

[84] Katy Robjant, Rita Hassan and Cornelius Katona, "Mental health implications of detaining asylum seekers: systematic review", *British Journal of Psychiatry*, vol. 194, No. 4 (April 2009).

[85] G. Coffey and others, "The meaning and mental health consequences of long-term immigration detention for people seeking asylum", *Social Science and Medicine*, vol. 70, No. 12 (June 2010).

[86] See A/HRC/13/30, para. 58.

[87] OHCHR, "Recommended principles and guidelines on human rights and international borders" (Geneva). Available at https://www.ohchr.org/Documents/Issues/Migration/OHCHR_Recommended_Principles_Guidelines.pdf.

[88] See Human Rights Committee general comment No. 35 on liberty and security of person, para. 3.

[89] See A/63/175, paras. 47 and 65.

from these attitudes and discourse not only harms the mental health and well-being of people on the move, but also threatens the development of enabling environments and may be therefore detrimental to the mental health and well-being of the general public. This includes children and adults in host societies, including the health-care workers who live there and may end up reproducing discriminatory practices.

79. **The xenophobic actions and words of people in positions of political power have a negative impact on the right to mental health. They help to create hostile emotional and psychosocial environments and erode the quality of human relationships, bringing mistrust, disrespect and intolerance into societal life.**

80. **The ultimate and crucial goal of States and stakeholders should be to stop these trends and develop strong communities characterized by good-quality human relations. Specific measures have little impact if enabling environments are not created and supported for the realization of everybody's rights, including the rights of people on the move and the right to health of all.**

81. **As we mark the seventieth anniversary of the adoption of the Universal Declaration of Human Rights, States and stakeholders are reminded that violations of the right to mental health can come from words and actions, notably those of State officials. Xenophobic rhetoric and actions must be halted.**

82. **The good practices that have been identified in the report could be replicated. The Special Rapporteur expresses his appreciation to those States, civil society actors, health-care workers and all stakeholders who have striven to protect and promote the rights of people on the move and to realize their right to mental health.**

83. **In order to address comprehensively the issues of the report, the Special Rapporteur recommends that States:**

(a) **Take immediate steps to repeal laws and policies that criminalize irregular migration or that, based on immigration status, impede the ability of people on the move to participate in or develop meaningful relationships in their host communities, work, obtain an education or have access to services, including mental health care and support;**

(b) **Prohibit immediately and eliminate without delay the detention of children and other practices that are not in their best interests, including the detention of families, family separation and obfuscation of family reunification;**

(c) **Prohibit immediately the immigration detention of migrants with psychosocial, cognitive or intellectual disabilities and ensure that decisions relating to the entry, stay, naturalization and expulsion of people on the move cannot be made solely on the basis of health status, including mental health status;**

(d) **Work progressively to end all forms of immigration detention and, in the exceptional circumstances where this is used, ensure that procedural safeguards are implemented fully and that immigration detention is monitored by independent mechanisms to prevent torture, ill-treatment and violence and to prevent related interferences with the realization of the right to physical and mental health;**

(e) **Ensure that detained migrants are held in conditions that satisfy health standards and have access to essential health-care services, including mental health care and support services;**

(f) **Establish binding and effective firewalls between service providers and immigration enforcement authorities, ensuring that no enforcement operations are carried out in or near mental health-care or support facilities;**

(g) **Develop direct, rights-based mental health care and support services for people on the move. These should address their needs for safety, for community participation and for livelihoods; acknowledge that the social, cultural, economic, political and legal determinants of mental health and well-being should inform interventions; cater to the cultural, religious and linguistic needs of users; and be suitable to their context;**

(h) **Establish individual screening and assessment procedures for people on the move, to identify survivors of sexual and gender-based violence and torture, people with intellectual, cognitive and psychosocial disabilities and other people on the move with mental health and well-being needs;**

(i) **Ensure the sustainability and non-discrimination of mental health care and support interventions for all people, including people on the move, through effective referrals of people on the move to appropriate services and through the broad incorporation of their needs into existing mental health systems;**

(j) **Include human rights education, including on the right to mental health and the rights of people on the move, in the training of all front-line workers interacting with them, including all health-care workers;**

(k) **Ensure that specialized health-care professionals work alongside community-based health-care workers, social service professionals and peer supporters on matters concerning the mental health care of and support for all people, including people on the move;**

(l) **Foster cooperation between humanitarian and development actors in the field of mental health and refrain from developing parallel health-care systems**;

(m) **Take steps to reverse the reliance on institutionalization, overmedicalization or other forms of rights-violating mental health interventions;**

(n) **Prioritize funding for mental health in national budgets;**

(o) **Introduce appropriate accountability mechanisms, including the monitoring of mental health care and support services and detention settings, to ensure that people on the move have access to redress where necessary.**

84. **The Special Rapporteur calls upon all stakeholders, including civil society organizations, health-care workers, academia, the international community and donors, who engage with the political, humanitarian and public health responses to people on the move:**

(a) **To prioritize funding for mental health in the realm of international development and humanitarian assistance**;

(b) **To increase resources, training and capacity-building in the field of mental health and support services for all persons, including people on the move;**

(c) **To foster inclusive societies that recognize human diversity and the contribution of all people to the communities where they live;**

(d) **To move towards more holistic models of collective healing for communities, with a focus on the key determinants of mental health, including healthy community relationships and inclusion;**

(e) **To work towards community-based mental health care and support services staffed by a combination of providers, focusing on various aspects of well-being, including psychological, social, medical, legal, economic and spiritual well-being;**

(f) **To engage with mental health care and support staff and front-line workers who interact with people on the move to raise awareness of their right to mental health and address the challenge of discrimination in service settings.**